

**Certified Nurse Midwives  
Credentialing Review Meeting #1  
Public Meeting  
Minutes**

This is a draft. Minutes  
have not been approved  
by the State Board of  
Health.

Wednesday, September 16<sup>th</sup>, 2026, 1:00pm

**MEMBERS:** Mark Malesker, PharmMD, FCCP, FCCM, FASHP, BCPH; Tami Dolphens, PA-C; Kevin Low, DDS; Judy Neville, CPhT, CSPT; Brandon Holt, BSRT [R] (CT) (ARRT); Stacy Waldron, PhD; Jacob Sikes

**STAFF:** Emma Davis, Emma Soukup

**1. Call to Order and Roll Call**

Jacob Sikes, Technical Review Committee Chair, called the first meeting of the certified nurse midwives credentialing review process to order at 1:09 PM on September 16, 2026, in the Goldenrod Conference Room in the Lower Level of the Nebraska State Office Building in Lincoln. Copies of the agenda, the procedure manual, the application for credentialing review, and multiple letters of support were mailed electronically to committee members prior to the meeting and posted on the Health and Human Services website. The following members were present: Mark Malesker, PharmMD, FCCP, FCCM, FASHP, BCPH; Tami Dolphens, PA-C; Kevin Low, DDS; Judy Neville, CPhT, CSPT; Brandon Holt, BSRT [R] (CT) (ARRT); Stacy Waldron, PhD; Jacob Sikes. There were no committee members who were not in attendance. Quorum met.

Staff and others in attendance: Emma Davis, Emma Soukup

A copy of the Open Meetings Act was available in the meeting room.

**2. Adoption of the Agenda**

- Dr. Low made a motion to approve the agenda, seconded by Dr. Dolphens; voting yes: 5 (Malesker, Neville, Holt, Waldron, Sikes); voting no: 0; not voting: 0. Motion carried.

**3. Technical Review Committee Introductions**

- The technical review committee introduced themselves:
  - Kevin Low, former dentist and former member of the Board of Health;
  - Mark Malesker, pharmacist faculty at Creighton;
  - Tami Dolphens, physician's assistant, currently working at Creighton, served on the physician's assistant licensing committee for 10 years;
  - Stacy Waldron, licensed psychologist, working in the out-patient program at Bryan Counselling Center, serving 10<sup>th</sup> year on the Board of Psychology, serving on the Association of State Mental Health and Psychology Boards' Board of Directors;
  - Jacob Sikes, serving on the Board of Health, chair of this technical review committee, works in orthotics and prosthetics;
  - Brandon Holt, working as the radiology and oncology director at CHI Health St. Francis, serving 15<sup>th</sup> year as the chair of the Board of Medical Radiography;
  - Judy Neville, working at UNMC College of Pharmacy teaching pharmacy students and pharmacy technicians.

**4. Applicant group presentation – Modernizing the Certified Nurse Midwifery Practice Act**

- Presented by Elizabeth Mollard, PhD, CNM, WHNP, IBCLC on behalf of Nebraska Certified Nurse-Midwives (the applicant group).
- Mollard thanked the technical review committee for their time.
- Mollard introduced herself. She has been a registered nurse for 21 years and a nurse practitioner for 18 years. When she'd been a nurse practitioner for about 10 years, she became a nurse midwife.
- Mollard pointed out that two different groups of APRNs are regulated very differently but have the same foundational training: nurse midwives and nurse practitioners.
- Mollard began her presentation by explaining why the applicant group is asking for change:
  - Nebraska has a maternity care access problem.
  - Nebraska already licenses a workforce it is not using.
  - The limits on that workforce are regulatory, not clinical.
- She explained that 54.8 percent of Nebraska's counties are maternity care deserts. The state ranks 40<sup>th</sup> for preterm birth rate of 52 states and territories. The maternal death rate is 25.1 maternal deaths per 100,000 births compared to 18.6 nationally. And, the state ranks 51<sup>st</sup> of 51 for midwifery integration.
- She explained that Certified Nurse Midwives (CNMs):
  - Are advanced practice registered nurses (APRNs),
  - Complete graduate-level midwifery education,
  - Have been a licensed profession in Nebraska since 1984,
  - Are nationally certified through AMCB,
  - Provide prenatal, birth, postpartum, newborn, gynecologic, and primary care,
  - And already practice in hospitals, clinics, rural communities, and health systems.
  - Additionally, CNMs can work in birth centers, but Nebraska no longer has any.
- She explained that the demand for midwifery care is increasing in Nebraska.
- Mollard explained the process for becoming a licensed CNM in Nebraska:
  - Earn a bachelor's degree,
  - Pass a national licensure examination,
  - Practice as a nurse,
  - Earn a graduate degree,
  - Then pass another national certification examination.
- Mollard then explained that nurse-midwife led care improves certain maternal health outcomes. It results in fewer cesarean births, fewer instrumental births, more spontaneous vaginal birth, better prenatal care engagement, fewer preterm births, lower rates of low birth rate, higher breastfeeding rates, better reported experience of care.
- Mollard told the group that Nebraska has nurse midwives that the state is not using because of the regulatory scheme currently in place. Six in ten CNMs are not attending births in the state. Mollard stated this is in part because of inability to find a supervising agreement with a physician.
- She then explained how Nebraska is a national outlier in two related cases:
  - It is one of only two states (the other being Georgia) where CNMs are required to have a supervising physician.
  - It is the only state where it is a felony for CNMs to attend a home birth.
- Mollard explained more about the physician practice agreement currently required for CNMs. She said that the actual document is not doing what it was intended. The average distance between doctors and midwives involved in these agreements is 279 miles, meaning that these physicians are not actually physically close enough to assist with emergency C-sections. Many of these agreements are actually purchased from doctors. This is in part because the strict language of these agreements ties the doctor's license to the CNM's in terms of liability, meaning that often collaborating physicians don't want to sign them even if they have a good working relationship with a CNM.
- Mollard explained that there are four different types of advanced practice registered nurses (APRNs): certified nurse practitioners (CNPs), certified registered nurse anesthetists (CRNAs), certified nurse midwives (CNMs), and clinical nurse specialists (CNSs). They all have the same educational standard but

are regulated unequally. In Nebraska, nurse anesthetists received full practice authority in 2002 and nurse practitioners received full practice authority in 2015. Nurse midwives are still required to have a physician agreement.

- She then explained the legislation that the application group introduced last legislative session. The language of the legislation has been changed due to stakeholders' input. Stakeholders included physician organizations, hospitals, nursing organizations, maternity quality leaders, health systems, and practicing Nebraska CNMs. The legislation is largely modeled on a similar law from North Carolina.
  - It consists of two components: granting CNMs full practice authority and planned home birth authority.
- Mollard evaluated the "full practice authority" against the credentialing review criteria and explained:
  - Practice authority would be granted after 2,000 transition hours of practice.
  - The proposed legislation lists the explicit authority of CNMs.
  - Evidence suggests better safety and outcomes with full practice and authority for CNMs as well as increased access and workforce.
  - The six components:
    - Present scope inadequately addresses public health, safety, or welfare: Supervision ties practice authority to physician availability, not competence.
    - The change would benefit public health, safety, or welfare: Increased practice authority creates better outcomes and increases rural access.
    - No significant new danger is created: There are no new tasks, patient populations, or settings and no states that have made this change have reversed it.
    - Current education and training adequately prepare practitioners: All functions are already taught to CNMs in their current education and training.
    - Post-professional programs and competence assessments are available: CNMs are certified and the transition to practice pathway is modeled on an existing structure.
    - Adequate measures exist to assess competence and act on it: Licensure, renewal, complaint investigation, discipline, mandatory reporting, hospital credentialing, and NPDB reporting. None would be removed by dissolution of supervising agreement.
- Mollard then evaluated the "home birth" proposal against the criteria and explained:
  - Home birth is a very uncommon practice.
  - Nebraska is the only state that makes it a felony for a CNM to attend a home birth.
  - No comparable country has banned home birth.
  - Not a claim that a home birth with a CNM attending is perfectly safe. It is considered reasonably safe for certain pregnancies. It is a woman's decision, and women are choosing to do this in Nebraska.
    - Home births are not illegal. CNMs are prohibited from attending. Physicians are not prohibited, but most would decline to do so.
  - The prohibition of home birth in Nebraska has not prevented it from occurring. 721 intentional home births were recorded in the 10 years that the prohibition has been in place. This number is possibly underreported because people do try to hide their home births.
  - The prohibition has prevented protections for women giving birth at home.
  - For low-risk pregnancies, home birth outcomes are good. There are consistently fewer interventions for mothers and absolute mortality is low.
  - The CNM would have all the materials necessary, including medical equipment and medications, and would have a registered nurse with them. Mollard explained that the people currently attending home births do not have these things with them, are not health care providers, and do not have the proper training.
  - Certain things can increase the risk of home birth: multiples (twins or triplets), breech at term, preterm birth, and prior cesarean. In the proposal, none of these can happen at home.
  - The six criteria:

- Present scope inadequately addresses public health, safety, or welfare: The prohibition does not prevent home birth, it prevents the most qualified attendant from being present.
  - The change would benefit public health, safety, or welfare: It replaces an unregulated environment with a structured one with eligibility requirements, informed consent, and provider standards. A CNM can also follow a mother into the hospital since they also practice there.
  - No significant new danger is created: The change would reduce risk by allowing qualified individuals to attend home births whereas now only unqualified individuals can.
  - Current education and training adequately prepare practitioners: Out-of-hospital competencies are core in CNM education.
  - Post-professional programs and competence assessments are available: the same infrastructure as the previous component, plus emergency skills maintenance and site-specific readiness requirements
  - Adequate measures exist to assess competence and act on it: Board disciplinary authority is not limited by practice setting. The proposed risk stratification, documentation, and reporting requirements give the Board a richer basis for monitoring.
- Nebraska is the only state where this prohibition exists in statute.
- Mollard summarized:
  - Nebraska needs more access to educated and qualified maternity clinicians.
  - CNMs are educated, nationally certified, licensed, and accountable clinicians.
  - Where midwives lead care, outcomes are good.
  - Align Nebraska's laws on homebirth with the rest of the country and world.
  - The applicant group asks the TRC to recommend the proposal.
- She then presented a slide with sources to conclude and opened the floor to questions.

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## 5. Technical Review Committee questions

- **Q:** It seems like the applicant group is asking for two separate things: the removal of the physician supervision requirement and the repeal of the prohibition against midwives' attendance at home births. Would the applicant group have a focus between the two or would they want both?
  - **A:** The applicant group wants both. The goal is to increase access to maternity care and allow midwives to practice in rural areas, reducing maternity care deserts.
  - **Q:** What does the removal of the supervision requirement have to do with the allowing of midwives to attend home births? You wouldn't need both?
    - **A:** Correct, they are not connected necessarily, the applicant group is just seeking both at this time.
- **Q:** Where does the data come from that supports the idea that women giving birth at home will hire a midwife?
  - **A:** There will always be people doing things outside of a regulatory scheme, but people typically do hire someone to attend their home birth and currently, hiring a CNM is not an option.
- **Q:** What are the patient demographics that midwives typically see? Is there a specific age? Income level?
  - **A:** There's a mix, as with every provider. Maternity providers, though, including midwives, tend to see a higher level of Medicaid patients because when someone is pregnant, the baby they're carrying counts as a person in their family, which helps them to qualify. Does that answer the question?
  - **Q:** Yeah, I wondered if it was, for example, a large number of 17-year-olds or something like that.
    - **A:** Yes, we do see teen moms sometimes, but in Nebraska, teen moms are not emancipated as they are in some states, so they're still under their parents.
    - We take care of about 11% of babies born in Nebraska and we're all over, so it's not as if just one demographic is drawn to midwifery care. Typically, higher educated women do choose midwifery care, but we do see all sorts of people from all walks of life.
- **Q:** Right now, are midwives credentialed with a facility? And with your proposed change, would they still be credentialed with a facility?
  - **A:** Yeah, if they are practicing in a facility. They are APRNs, so it would be the same as any other APRN and it would continue to be the same.

- **Q:** So, say there was a home birth and the mom needs to be transferred to a facility, but the midwife was not credentialed at that facility.
    - **A:** So there was a law passed in 2011 that states that a hospital cannot deny privileges based on a credential to a CNM. However, hospitals can create barriers, such as saying you must have a doctor sponsoring you. So, we could add language to prevent them from doing that.
- **Q:** It is my understanding that physicians are held accountable for physician assistants (PAs). Do they have more education than nurse practitioners? Or no?
  - **A:** No. It's a different model, so PAs are meant to work very closely with physicians, but we also see them starting to work more independently as well. Their level of education is different, but comparable. Another difference is that PAs come into graduate school having completed the prerequisites but not necessarily having done clinical hours. Nurses are required to have done clinical hours before graduate school.
- **Q:** How many hours are APRNs required to have completed before licensure?
  - **A:** It depends on the accrediting body and the specialty they are doing. It's typically about 1000.
  - **Q:** Okay, and you are asking for this group to have 2000, which is about a year?
    - **A:** Yes, 1000 hours are completed in the graduate program and these 2000 would be post-graduate.
- **Q:** Can you overlay the maternity care desert map with a map of the presence of midwives?
  - **A:** Sure!
  - **Q:** I'd just like to see it because a lot of times these requests come out of Lincoln or Omaha and claim there's a need for access to care in Western Nebraska, but there isn't even anyone practicing there.
- **Q:** In a situation where a midwife gets into trouble caring for a pregnancy in a rural location where healthcare resources aren't anywhere close, what would happen?
  - **A:** Just because something changes legally doesn't necessarily mean it's something you should always be doing. You would have to make a plan involving the closest OR and the closest place that can stabilize a baby. If you work in a rural area where they have to transfer a baby, there needs to be a plan to transfer that baby, and someone will have to be responsible for stabilizing the infant in transfer. But it's not unheard of to have an extended plan for neonatal stabilization.
- **Q:** Who would determine if a pregnancy is a low-risk pregnancy?
  - **A:** A nurse midwife can make that determination. Everyone needs to follow the standard of care. And that usually includes an early trimester ultrasound, another ultrasound at 20-something weeks, where you are looking at those things, monitoring other things noted in the standard of care such as blood pressure and labs.
- **Q:** Are you able to bill insurance directly, Medicaid and others, and receive payment for your services?
  - **A:** Yes.
- **Q:** So, you want this all, what if you have to split criteria A (removal of physician supervising agreement requirement) and criteria B (removal of prohibition against midwives attending home births)?
  - **A:** Nurse midwives strongly desire full practice authority. We want equality with other APRNs. A state cannot say, when the education is the same, that two groups get it and one group does not. And the one group that doesn't happens to be all ladies and also the group taking care of all the women. And that feels very purposeful, right? So that's what we want, we want to be able to care for patients, open businesses, and increase access to maternal healthcare. Not as many nurse midwives are interested in doing home births. But also, that's the no-brainer. There's nowhere else in the entire world that limits its citizens this way. If we had to split it, we really would like full practice authority. But, the consumer, the 1% that desire home births, are very vocal about it. Currently, Nebraska has an environment where those women are being exploited. Pushing this underground, when we know it's a practice that's continuing to happen, is not being protective of consumers.
- **Q:** Are we going to hear opposition?
  - **A:** I don't know. We have worked closely with the Nebraska Medical Association, they are here, they have written a letter of support. The hospital is supporting us. We've had a number of conversations with the pediatricians, we made that compromise with them, and I've told them we are very willing to work with them. I don't know what will happen, I think in general the healthcare community is going to support us. There might be consumers who find that this is too restrictive. I don't know, but nobody has alerted me specifically to opposition.

- **Q:** First of all, great job presenting. (Mollard: Thank you.) But what I'm hearing you say is that there are all of these midwives who are not currently practicing and if we change this, then they will begin practicing again, increasing the workforce. Why is that?
  - **A:** Some are unemployed right now because not everyone can afford to buy a collaborative practice agreement as part of their business expenses. They can be up to \$1,000 per month. I know someone right now who has a rate of \$500 per month. But then you have to build clientele, there are more barriers in order to practice in a birthing facility. I've also been working at UNMC trying to start a nurse midwifery program since 2020 and they're kind of waiting for this change to take place.
- **Q:** You're talking about a model I'm not familiar with. I'm familiar with CHI, which has agreements with midwives and their physicians. But what you're talking about is this online agreement where doctors charge about \$1,000 per month. But that's not how everybody practices.
  - **A:** Correct, that is not how everyone practices. I also worked at CHI, and they provided me with a doctor and with a ton of support. They had a very supportive care team, but that is not everyone's situation. And that's how that will continue to work, there will be an association of midwives and an association of obstetricians at the same employer, and they will have guidelines about how they are supposed to interact with each other and consult.
- **Q:** Are there midwives who would be opposed to this because they want to have a physician oversee them?
  - **A:** No, there's not a single one. And I know every single one. Because this agreement does not change our relationship with physicians. In healthcare, we collaborate with each other without the state putting in statute that you must collaborate with this other person.
  - **Q:** So, the statute isn't about collaboration, it's about supervision.
    - **A:** Yes.
- **Q:** 113 active licenses, 44 are attending births, there are 87 of those in clinical practice. I would assume that those 44 are included in the 87. (Mollard: correct.) What I'm hearing you say is if we remove the requirement for the collaborative agreement, we would see the rest of those twenty-something CNMs go into practice.
  - **A:** Not all of them, but I know of at least five. Because some people get to a certain age and they're done catching babies or they want to work in a family planning clinic. So it wouldn't be everybody, but there are two people living in rural areas who are not practicing and would like to be.
- **Q:** So, how does becoming a CNM work? Do you go into a CNM track immediately or after completing APRN general?
  - **A:** After completing APRN general. And then our degree will be a master's in science and nursing or in nursing practice, you don't get a degree in being a CNM, so we all have the same degree. It's the specialty clinical hours related to your specialty.
  - **Q:** Currently in their day-to-day, what are CNMs proscribing? If you ignore birthing services.
    - **A:** Basic primary care, women's care, gynecologic services. We might refill someone's metformin if they've been on it their whole life, for example, but mostly we're prescribing things related to family planning and gynecologic care.
    - **Q:** If the physician supervision agreement requirement is removed, would insurance become unaffordable for CNMs who are practicing without one?
      - a. **A:** It will be expensive if you are doing birth care, because it is expensive to do birth care. If you're employed by a hospital, they will usually purchase your agreement and there are things they can do to get it cheaper. But insurance has nothing to do with our collaborative agreement.
- **Q:** In your development and your training as a nurse, where do you become comfortable with prescribing as you get into practice? And will all CNMs have that confidence?
  - **A:** It's from education and clinical training. One of the nice things about nurse midwifery and women's health is that we only do so many things. A general practitioner needs to know a lot about a lot of things. We only need to know a lot about a few things. We test our grad students on dosing, but it's not terribly difficult because a lot of our medications are very specific to the things we are doing. If we're having complicated dosing, that's out of our wheelhouse and out of our scope.
  - **Q:** So, you would check with a pharmacist.
    - **A:** Yes, and I do that now, for example if a patient develops an infection during labor, we order a medication and call the pharmacist to have them dose it for us. That's best practice. And that's the thing, not everything needs to be in the law, that's not really how providers of all kinds work. A lot of this is just going out there and doing good clinical practice. And adhering to the standard of care.

- **Q:** So, what would you do if you were out in rural Nebraska, and you're taking care of this woman and you're all she's got? She doesn't have anyone else to take care of her other medical needs.
  - **A:** So, our scope of practice is limited. We can't do everything, so a nurse midwife would not be able to do that. And that isn't something you would need to write into statute for us to know.
  - **Q:** Okay, maybe I am misunderstanding, but sometimes when women go and their health is being taken care of, that feels like everything. (Mollard: You mean, you're going in for a well-woman visit and now you're going to talk about other things as well?) Yes, now I'm sad, I'm depressed, can I have my ADHD meds? I haven't been diagnosed, but I'm bringing you all these little things I got from ChatGPT and now I know I've got ADHD because oh my gosh, my mind's racing! And then, I also need this and then I need that. And the next thing you know...
    - **A:** Yes, so actually in our training programs, we do talk about how to set boundaries on visits. So if you are doing, for example, a preventative healthcare visit and somebody brings up something unrelated to it, we would tell them what we are going over today and tell them that while their other concern is important, we'll need to refer them to someone else to address it. Even in rural Nebraska, we can refer.
- **Q:** You mentioned an RN would need to be present if a midwife was doing a home birth in order to administer medications. Is an assistant present when a CNM supervises a home birth always?
  - **A:** Yes, because you have two patients, even before the one comes out. So ideally, you actually have two people assisting you. Does that need to be written into the law? I don't think so. But should it be written into regulation? Probably.
- **Q:** Would nurse midwives be reimbursed by Medicaid for home births?
  - **A:** I don't think they would be right away. But they might cover it eventually, they do in most states.
- **Q:** APRN NPs in the state of Nebraska have independent practice after 2,000 hours. So if you are an APRN NP, licensed in the state of Nebraska, and you also become a nurse midwife, you could do everything you're asking for in this?
  - **A:** Until it's time to deliver the baby. And that's because of the different population focuses.
- **Q:** What percentage of these 113 nurse midwives are also APRN NP?
  - **A:** I don't know, but a lot of people go back and become an NP when they can't find a CNM job.
- **Q:** If Nebraska doesn't offer the education, where did you go to become a nurse midwife?
  - **A:** The University of Colorado, which was great because they have huge numbers of midwives practicing in that state. They have three or four midwives practicing in a hospital at a time. And I did some of my time here at Nebraska Medicine as well.
- **Q:** So, would these types of licenses have reciprocity across state lines?
  - **A:** I don't think our licensure necessarily, but it's the same certification across state lines.
  - **Q:** And you're not seeking licensure, right?
    - **A:** We have licensure, we are already licensed.
    - **Q:** And you are licensed as?
      - a. **A:** APRN CNM – so we are licensed as advanced practice registered nurses.
      - b. **Q:** You have a license, so then you're looking for a certification?
        - i. **A:** We actually want to expand our scope.
        - ii. **Q:** And you also want to practice independently?
          - 1. **A:** That would be the scope expansion, yes. We actually want to practice exactly the same as we are now, just without supervision.
- **Q:** So there is not a specific license for midwives, you're licensed as ...?
  - **A:** APRN-CNM. So the four APRN groups are APRN-NP, APRN-CRNA, APRN-CNM, APRN-CNS. But we're all APRN.
  - **Q:** But none of those are midwives?
    - **A:** No, APRN-CNMs are midwives, we are licensed and have been since 1984.
- Sikes: You did great!
- Mollard: Thank you! And, I do just want to say one thing. People in rural communities are three times more likely to die at any time. And some of the things we're going to talk about aren't necessarily nurse midwife related, but there are issues when you have a baby at a hospital, too. So I just want us to be mindful of that, that we need to strengthen those rural healthcare hubs so we can get there and we can transfer clients to the hospital. And if we do make community birth more widespread, we need to bring that above so we can see what's happening and strengthen transferring there too.

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## 6. Interested parties

- Sikes: Does anybody else have any questions or comments that they would like to add to this?
- Amy Reynoldson: I don't have questions, but I have comments. I wasn't planning to speak, but I would like to bring some clarity because I'm hearing some questions and I think some clarity could come from the Nebraska Medical Association. Amy Reynoldson, executive vice president of the Nebraska Medical Association. We did submit a letter of support. If you have not read it, I would encourage you to read it. We support certified nurse midwives to seek independent practice, not a certification, not a license. They are already licensed, they are already out there delivering lots of babies, working very closely with physicians. We definitely support that. It's been an honor to work with them.
- Low: Let me interrupt here, so you're considering a registered nurse, an APRN as a licensed professional?
- Several: They are.
- Low: So, they do carry licenses? Just want to make sure.
- Reynoldson: Yes, and those are two different entities. A registered nurse and an APRN are different license types. Just like an MD is a different license type from a PharmD. They are credentialed, able to practice in hospitals, health care clinics, ambulatory surgical centers, you name it. Any they're also credentialed with all the payers to get comparable reimbursement working in that supervisory agreement with physicians. It's been an honor to work with Libby and the certified nurse midwives and the nursing association over the last two years. We have a problem in the state of Nebraska and that is unregulated, unlicensed, lay midwives attempting to deliver babies at home with no plan, no consent, no arrangements with EMS, no arrangements with hospitals. And our physician members are here to tell you that a planned pregnancy at home that goes awry, taking them into a hospital with no birthing capabilities is your worst nightmare. And that's happening and we just had another death about ten days ago. It's happening. We've had multiple deaths. The irony of this year is that when legislation was introduced that week regarding the freestanding birth centers, we had two deaths: planned home births with lay midwives. Two deaths. So our physicians are finding out about it because they're getting the call from the attending physician that is receiving that child and that mother being brought in. And word travels very fast, so we're understanding that 721 home births is very underreported in the state of Nebraska. There are a lot of home births not being reported and it's incredibly dangerous. We need to regulate and we need the absolute safest individuals with the most knowledge out doing that. And saying that, our members have strong concerns about home delivery. We've had conversations very openly with Libby and the certified nurse midwives. We get it, it's going to happen. But would we rather have a really experienced, knowledgeable individual planning that, working with EMS, working with hospitals to reduce the burden and ultimately reduce costs on our healthcare system?
- Unknown 1: Can you define "lay midwife?" That's a term we haven't heard before.
- Reynoldson: Unlicensed, little to know education.
- Unknown 2: Where are they coming from? Are they just watching a YouTube video and going for it?
- Unknown 3: Are they calling themselves doulas?
- Reynoldson: They may be calling themselves doulas, yes.
- Unknown 3: What are the ethical and legal ramifications for those people when things turn out bad? Does anything really happen to them? Do they keep doing things that way?
- Reynoldson: That's a great question and we probably don't have time to go into that right now. We are working on that.
- Mollard: There's no accountability right now. It's hard to find the people accountable.
- Reynoldson: We're working on that and in conversations with the Attorney General's office. I just want to make certain that folks understand that certified nurse midwives are very important, critical members of the healthcare team. They've been a part of the healthcare team for decades and have been treating patients. We support this application, both them seeking independent practice and the home birthing. We do not believe it is going to be a large percentage of the nurse midwives doing home births, specifically because of the medical liability risks associated with that. There are only a couple medical

liability insurers that will cover that and neither are credentialed in the state of Nebraska to write insurance for those that want to do home delivery. So we will have to work to get insurance in the state. But I just wanted to clear the air because I felt like there was some confusion about what's being asked. They are kind of going for multiple asks within their application.

- Low: Where will you find opposition for this?
  - Public member: The black market women who are holding themselves out as credentialed but are essentially practicing without any licenses. Not just doulas, they call themselves professional midwives and they are attending home births without the proper authorities or regulations to do so. And Libby can only say anecdotally, but there are things happening that we can only see when there are indictments and charges and negative outcomes at hospitals.
  - Unknown 1: Brings up a concern that there aren't academic programs in the state, so would criteria A really increase access to care?
  - Reynoldson: Explains that that isn't part of the scope of what the TRC is charged to consider and typically when independent practice is allowed, UNMC will change to create programs to train those types of professionals.
  - Unknown 4: Just to clarify, you guys are fully in support of lifting the requirement for this supervisory agreement?
  - Reynoldson: Yes. And it's based on that we know practically and realistically, they aren't going to be able to work without working with physicians and physicians are going to continue working in partnership with CNMs.
  - Sikes: Thank you so much. Is there anyone else?
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## 7. Adjournment and next steps

- Sikes: If there're no further questions or comments, then we'll call the meeting adjourned.
- Next meeting: October 6<sup>th</sup>, 9 AM in the Sarpy room.

Note: *If you would like any attachments mentioned in these minutes, or have other questions, please contact Emma.Soukup@nebraska.gov.*

Updated: September 18, 2026